STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00118544 and IN00119399. Complaint IN00118544 - Substantiated. Federal/State deficiencies related to the allegation are cited at F281, F282, F514 and F9999. Complaint IN00119399 - Substantiated. Federal/State deficiency related to the allegations is cited at F312. Survey dates: November 15, 16 and 19, 2012 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Survey team: Penny Marlatt, RN Census bed type: SNF/NF: 85 Total: 85 Census payor type: Medicare: 15 Medicaid: 62 Other: 8 Total: 85	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 11/27/12 by Suzanne Williams, RN			

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F0281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on interview and record review, the facility failed to ensure facility staff followed the physician's orders and professional standards of quality in administering scheduled medications in a timely fashion for 1 of 3 residents in a sample of 4 who were reviewed for pain control medications, resulting in one resident becoming lethargic, and being sent to the local emergency room (ER) and treated for narcotic overdose. In addition, this same resident received a portion of other morning medications approximately 2 hours earlier than ordered. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 11-15-12 at 4:32 p.m. Her diagnoses included, but were not limited to, chronic back pain, muscle atrophy, peripheral neuropathy, congestive heart failure, anxiety, dementia and osteoporosis. Review of her most recent Minimum Data Set (MDS) assessment, dated 10-1-12, indicated she had mild	F0281	**F 281 Services Provided Meet Professional Standards** The services provided or arranged by the facility must meet professional standards of quality. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** * Resident B was sent to the local hospital for treatment. Resident B returned to facility within same day with no injuries. * Resident B receives medications the prescribing physician has ordered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * Director of nursing and/or designee will conduct rounds on all shifts to monitor the timeliness of the medication administration pass.* All licensed staff have been inserviced by the Director of Nursing and/or designee on proper medication administration techniques by December 11, 2012. * Skills validations related to medication administration were	12/11/2012

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	cognitive impairment. It indicated she had frequent, severe pain for which she received pain medications on a routine basis, as well as on an "as needed" or "prn" basis. Review of the nursing notes, dated 10-22-12 at 8:05 a.m., indicated "Noticed res [resident] during breakfast not eating, when attempted to talk to res, res was extremely hard to arouse. Res will open eyes for a second, and when responds unable to understand what she is saying..." The note then indicated vital signs were checked and the physician notified. The physician ordered for the resident to be sent to the local ER for evaluation and treatment. Notes indicated the resident's POA (power of attorney) was notified of the resident's change in condition and the ambulance was on site by 8:40 a.m. to transport the resident to the local ER. An "ED [Emergency Department] Physician Documentation" form, dated 10-22-12, indicated Resident #B was treated that date for lethargy and altered mental status with no respiratory distress. It indicated she was discharged back to the facility at 2:56 p.m. with a discharge diagnosis of "narcotic overdose." A "Transport		completed on all licensed staff on all shifts by the director of nursing and/or designee by December 11, 2012. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** * * Director of nursing and/or designee will conduct rounds on all shifts to monitor the timeliness of the medication administration pass.* Licensed Staff have been inserviced by the director of nursing and/or designee on medication administration techniques/med errors by December 11, 2012. * Skills validations related to medication administration will be completed on all licensed staff on all shifts by the director of nursing and/or designee by December 11, 2012. * The director of nursing is responsible for compliance related to medication administration. * Non-compliance with medication administration procedures may result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * A Medication Errors CQI tool will be utilized by the director of nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months. * Audit tools will be submitted to	

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	Report Form" from the local ER, dated 10-22-12, indicated the resident received 2 doses of Narcan, a medication used to manage or reverse opioid overdosage, and 1/2 liter of IV fluids. In interview with the Director of Nursing (DON) on 11-16-12 at 1:10 p.m., she indicated the facility conducted an investigation into the circumstances of the resident's status. A document entitled, "Employee Communication Form," dated 10-23-12, indicated on 10-22-12 at approximately 8:10 a.m., the DON was notified that RN #1 had administered Resident #B's 8:00 a.m. medications at approximately 6:00 a.m. This document indicated, "This noncompliant action resulted in a resident being transported to the Emergency Room and noted to have Narcotic Depression [sic.] The resident then received Narcan x2 [twice] to reverse the Narcotic Depression." The DON indicated "If I recall, she clocked out at 6:34 a.m., but signed the meds out for 7:00 a.m. and told us she gave them around 6:00 a.m. She didn't want to stay over that morning and she said that was her way of helping the day nurse."		the CQI committee and if 95% compliance is not achieved, action plans will be developed as needed.	

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	A copy of RN #1's time clock documentation indicated she clocked in on 10-21-12 at 9:54 p.m. and clocked out on 10-22-12 at 6:34 a.m. In interview with the Administrator on 11-16-12 at 1:10 p.m., she indicated RN #1 "seemed to have no remorse whatsoever in regards to what happened to the resident or that she falsified records." The Administer indicated RN #1 was terminated from employment at the facility. In interview with Resident #B on 11-16-12 at 2:40 p.m., she indicated she was sent to the local ER "not too long ago. The doctor there told me the nurse [at the facility] gave me too much pain medicine...they gave me some kind of medicine that snapped me right out of it." In a written statement by RN #1, dated 10-23-12, she indicated, "On the night shift we start our 6A meds at 4A. On [10-22-12], I gave [initials of Resident #B] her Percocet at 4A and then her 8A meds at 6A When I worked 2-10 [p.m.], we started our 8P meds at 6P, so I did not think this was wrong & that I was doing anything wrong...I was trying to help the day nurse out before I had to leave..."			

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	In a written statement from LPN #1, dated 10-23-12, she indicated, "When I got to work at 5:55A, [name of RN #1] was sitting at the nurse's desk waiting on relief. When we were getting report, [name of RN #1] told me she had already gave all 8A meds on the short hall on [name of hallway] because she was going to be mandated to stay and [name of RN #1] stated, 'I am not staying over.'" Review of Resident #B's physician orders and Medication Administration Record (MAR) indicated she was physician ordered for Percocet, a pain medication, 10/325 mg (milligrams) 2 tablets by mouth every 6 hours at 6:00 a.m., 12 noon, 6:00 p.m. and 12 midnight daily, Ativan 0.5 mg, an anti-anxiety medication three times daily by mouth at 8:00 a.m., 12 noon and 8:00 p.m., and Oxycontin CR 20 mg every 12 hours by mouth at 8:00 a.m. and 8:00 p.m. Resident #B's narcotic count log indicated the Percocet was signed out by RN #1 as administered on 10-22-12 at 6:00 a.m., the Ativan was signed out by RN #1 as administered on 10-22-12 at 7:00 a.m. and the Oxycontin CR was signed out by RN #1 as administered at 7:00 a.m. Other medications ordered for a			

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	morning dose and initialed as administered by RN #1 on 10-22-12 were as follows: -Aricept 10 mg once daily by mouth at 8:00 a.m. -diltiazem 240 mg ER once daily by mouth at 8:00 a.m. -Colace 100 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -Augmentin 875 mg twice daily by mouth for 10 days for bronchitis (start date of 10-18-12) at 9:00 a.m. and 9:00 p.m. -Antivert 25 mg three times a day for 7 days for dizziness (start date of 10-18-12), at 6:00 a.m., 2:00 p.m. and 10:00 p.m. -Neurontin 800 mg three times daily by mouth at 8:00 a.m., 12 noon and 4:00 p.m. -ferrous sulfate 325 mg once daily by mouth at 8:00 a.m. -Chloroseptic throat spray or generic brand, sprayed on throat four times daily at 6:00 a.m., 12 noon, 6:00 p.m. and 12 midnight. -potassium chloride 20 milliequivalents, 2 tablets, once daily by mouth at 8:00 a.m. -Lasix 40 mg once daily by mouth at 8:00 a.m. -Aggrenox 25-200 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -folic acid 1 mg once daily by mouth at 8:00 a.m.			

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	-Flonase Nasal Spray 0.05%, 1 spray each nostril once daily at 8:00 a.m. -Protonix 40 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -Zoloft 150 mg once daily by mouth at 8:00 a.m. -Advair Diskus 250/50 1 inhalation by mouth twice daily at 8:00 a.m. and 4:00 p.m. -Spiriva Handihaler, inhale contents of 1 capsule once daily by mouth at 8:00 a.m. -Albuterol 0.083% (2.5mg in 3 milliliters of saline) 1 vial via nebulizer four times daily at 8:00 a.m., 12 noon, 4:00 p.m. and 8:00 p.m. -Lidoderm 5% Patch, apply one patch daily topically at 7:00 a.m. and remove daily at 7:00 p.m. -Coreg 6.25 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -lisinopril 10 mg daily by mouth at 8:00 a.m. The Administrator provided a document entitled, "Charge Nurse Position Description" on 11-16-12 at 4:45 p.m. This document indicated, "...administers medications and specialized treatments...as prescribed to residents on unit according to physician orders and in compliance with facility policies and procedures..." This document was signed by RN #1 on 6-1-12.			

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	The Administrator provided a document entitled, "Medication Pass Procedure" on 11-16-12 at 4:45 p.m. This document indicated under the heading of "Skill," "Meds administered within 60 minutes before and/or after scheduled time ordered," that RN #1 had successfully passed this skill. This document was signed by RN #1 on 6-9-12 and the instructor. The 2010 edition of "Nursing Spectrum Drug Handbook," preface, indicated, "Nurses are legally responsible for applying and ensuring the 'five rights' of drug administration...right patient...right drug...right dosage...right time...right route." This Federal tag relates to Complaint IN00118544. 3.1-35(g)(1) 3.1-35(g)(2)			

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F0282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure narcotic medications were given as ordered by the physician and not too close in administration time to other narcotic and/or anti-anxiety medications which resulted in 1 of 3 residents in a sample of 4 who were reviewed for pain control being sent to the local emergency room (ER) and treated for narcotic overdose. In addition, this same resident received a portion of her other morning medications approximately 2 hours earlier than ordered. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 11-15-12 at 4:32 p.m. Her diagnoses included, but were not limited to chronic back pain, muscle atrophy, peripheral neuropathy,congestive heart failure, anxiety, dementia and osteoporosis. Review of her most recent Minimum Data Set (MDS) assessment, dated 10-1-12, indicated she had mild	F0282	**F 282 Services By Qualified Persons/Per Care Plan** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** * Resident B was sent to the local hospital for treatment. Resident B returned to facility within same day with no injuries. * Resident B receives medications the prescribing physician has ordered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * Director of nursing and/or designee will conduct rounds on all shifts to monitor the timeliness of the medication administration pass.* All licensed staff have been inserviced by the Director of Nursing and/or designee on proper medication administration	12/11/2012

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	cognitive impairment. It indicated she had frequent, severe pain for which she received pain medications on a routine basis, as well as on an "as needed" or "prn" basis. Review of the nursing notes, dated 10-22-12 at 8:05 a.m., indicated "Noticed res [resident] during breakfast not eating, when attempted to talk to res, res was extremely hard to arouse. Res will open eyes for a second, and when responds unable to understand what she is saying..." The note then indicated vital signs were checked and the physician notified. The physician ordered for the resident to be sent to the local ER for evaluation and treatment. Notes indicated the resident's POA (power of attorney) was notified of the resident's change in condition and the ambulance was on site by 8:40 a.m. to transport the resident to the local ER. An "ED [Emergency Department] Physician Documentation" form, dated 10-22-12, indicated Resident #B was treated that date for lethargy and altered mental status with no respiratory distress. It indicated she was discharged back to the facility at 2:56 p.m. with a discharge diagnosis of "narcotic overdose." A "Transport		techniques by December 11, 2012. * Skills validations related to medication administration were completed on all licensed staff on all shifts by the director of nursing and/or designee by December 11, 2012. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** * Director of nursing and/or designee will conduct rounds on all shifts to monitor the timeliness of the medication administration pass. * All licensed staff have been inserviced by the director of nursing and/or designee on medication administration techniques/med errors by December 11, 2012. * Skills validations related to medication administration will be completed on all licensed staff on all shifts by the director of nursing and/or designee by December 11, 2012. * The director of nursing is responsible for compliance related to medication administration. * Non-compliance with medication administration procedures may result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * A Medication Errors CQI tool will be utilized by the director of nursing and/or designee weekly x	

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	Report Form" from the local ER, dated 10-22-12, indicated the resident received 2 doses of Narcan, a medication used to manage or reverse opioid overdosage, and 1/2 liter of IV fluids. In interview with the Director of Nursing (DON) on 11-16-12 at 1:10 p.m., she indicated the facility conducted an investigation into the circumstances of the resident's status. A document entitled, "Employee Communication Form," dated 10-23-12, indicated on 10-22-12 at approximately 8:10 a.m., the DON was notified that RN #1 had administered Resident #B's 8:00 a.m. medications at approximately 6:00 a.m. This document indicated, "This noncompliant action resulted in a resident being transported to the Emergency Room and noted to have Narcotic Depression [sic.] The resident then received Narcan x2 [twice] to reverse the Narcotic Depression." The DON indicated "If I recall, she clocked out at 6:34 a.m., but signed the meds out for 7:00 a.m. and told us she gave them around 6:00 a.m. She didn't want to stay over that morning and she said that was her way of helping the day nurse."		4 weeks, monthly x 2 months and quarterly x 1 for at least 6 months. * Audit tools will be submitted to the CQI committee and if 95% compliance is not achieved, action plans will be developed.	

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	A copy of RN #1's time clock documentation indicated she clocked in on 10-21-12 at 9:54 p.m. and clocked out on 10-22-12 at 6:34 a.m. In interview with the Administrator on 11-16-12 at 1:10 p.m., she indicated RN #1 "seemed to have no remorse whatsoever in regards to what happened to the resident or that she falsified records." The Administer indicated RN #1 was terminated from employment at the facility. In interview with Resident #B on 11-16-12 at 2:40 p.m., she indicated she was sent to the local ER "not too long ago. The doctor there told me the nurse [at the facility] gave me too much pain medicine...they gave me some kind of medicine that snapped me right out of it." In a written statement by RN #1, dated 10-23-12, she indicated, "On the night shift we start our 6A meds at 4A. On [10-22-12], I gave [initials of Resident #B] her Percocet at 4A and then her 8A meds at 6A When I worked 2-10 [p.m.], we started our 8P meds at 6P, so I did not think this was wrong & that I was doing anything wrong...I was trying to help the day nurse out before I had to leave..."			

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	In a written statement from LPN #1, dated 10-23-12, she indicated, "When I got to work at 5:55A, [name of RN #1] was sitting at the nurse's desk waiting on relief. When we were getting report, [name of RN #1] told me she had already gave all 8A meds on the short hall on [name of hallway] because she was going to be mandated to stay and [name of RN #1] stated, 'I am not staying over.'" Review of Resident #B's physician orders and Medication Administration Record (MAR) indicated she was physician ordered for Percocet, a pain medication, 10/325 mg (milligrams) 2 tablets by mouth every 6 hours at 6:00 a.m., 12 noon, 6:00 p.m. and 12 midnight daily, Ativan 0.5 mg, an anti-anxiety medication three times daily by mouth at 8:00 a.m., 12 noon and 8:00 p.m., and Oxycontin CR 20 mg every 12 hours by mouth at 8:00 a.m. and 8:00 p.m. Resident #B's narcotic count log indicated the Percocet was signed out by RN #1 as administered on 10-22-12 at 6:00 a.m., the Ativan was signed out by RN #1 as administered on 10-22-12 at 7:00 a.m. and the Oxycontin CR was signed out by RN #1 as administered at 7:00 a.m. Other medications ordered for a			

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	morning dose and initialed as administered by RN #1 on 10-22-12 were as follows: -Aricept 10 mg once daily by mouth at 8:00 a.m. -diltiazem 240 mg ER once daily by mouth at 8:00 a.m. -Colace 100 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -Augmentin 875 mg twice daily by mouth for 10 days for bronchitis (start date of 10-18-12) at 9:00 a.m. and 9:00 p.m. -Antivert 25 mg three times a day for 7 days for dizziness (start date of 10-18-12), at 6:00 a.m., 2:00 p.m. and 10:00 p.m. -Neurontin 800 mg three times daily by mouth at 8:00 a.m., 12 noon and 4:00 p.m. -ferrous sulfate 325 mg once daily by mouth at 8:00 a.m. -Chloroseptic throat spray or generic brand, sprayed on throat four times daily at 6:00 a.m., 12 noon, 6:00 p.m. and 12 midnight. -potassium chloride 20 milliequivalents, 2 tablets, once daily by mouth at 8:00 a.m. -Lasix 40 mg once daily by mouth at 8:00 a.m. -Aggrenox 25-200 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -folic acid 1 mg once daily by mouth at 8:00 a.m.			

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	-Flonase Nasal Spray 0.05%, 1 spray each nostril once daily at 8:00 a.m. -Protonix 40 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -Zoloft 150 mg once daily by mouth at 8:00 a.m. -Advair Diskus 250/50 1 inhalation by mouth twice daily at 8:00 a.m. and 4:00 p.m. -Spiriva Handihaler, inhale contents of 1 capsule once daily by mouth at 8:00 a.m. -Albuterol 0.083% (2.5mg in 3 milliliters of saline) 1 vial via nebulizer four times daily at 8:00 a.m., 12 noon, 4:00 p.m. and 8:00 p.m. -Lidoderm 5% Patch, apply one patch daily topically at 7:00 a.m. and remove daily at 7:00 p.m. -Coreg 6.25 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -lisinopril 10 mg daily by mouth at 8:00 a.m. The 2010 edition of "Nursing Spectrum Drug Handbook," indicated to closely observe the use of Ativan for CNS (central nervous system) depression, especially in the elderly, or when used in combination with other medications that can cause drowsiness, such as Percocet or Oxycontin. The Administrator provided a			

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	document entitled, "Charge Nurse Position Description" on 11-16-12 at 4:45 p.m. This document indicated, "...administers medications and specialized treatments...as prescribed to residents on unit according to physician orders and in compliance with facility policies and procedures..." This document was signed by RN #1 on 6-1-12. The Administrator provided a document entitled, "Medication Pass Procedure" on 11-16-12 at 4:45 p.m. This document indicated under the heading of "Skill," "Meds administered within 60 minutes before and/or after scheduled time ordered," that RN #1 had successfully passed this skill. This document was signed by RN #1 on 6-9-12 and the instructor. This Federal tag relates to Complaint IN00118544. 3.1-35(g)(2)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure a resident with a need for assistance in grooming was provided care and services to keep her fingernails clean and well-groomed, for 1 of 3 residents reviewed for personal hygiene in a sample of 4. (Resident #C) Findings include: Resident #C's clinical record was reviewed on 11-15-12 at 2:28 p.m. Her diagnoses included, but were not limited to, right frontal CVA (cerebrovascular accident or stroke), hemiplegia (one side of the body paralyzed), high blood pressure and carotid stenosis. Review of Resident #C's admission Minimum Data Set (MDS) assessment, dated 8-20-12, indicated she had mild cognitive impairment, had limited to no movement of one side of her body, and required extensive assistance of one person	F0312	**F 312 ADL Care Provided for Dependent ResidentsA resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** * Resident C was provided with nail care.* Resident C receives nail care with each shower and as needed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	12/11/2012

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	with personal hygiene, bathing, dressing and ambulation; it indicated she required extensive assistance of 2 or more persons with toileting. During observation of Resident #C on 11-15-12 at 1:58 p.m., her fingernails extended approximately 1/4 inch past the tips of her fingers. The fingernails had an ungroomed appearance with obvious dirt and debris under each nail. In interview with Resident #C at that time, she indicated her left arm and leg were "just useless." She indicated she needs assistance with toileting, showering and grooming because of this. Review of the resident's care plan, dated 9-18-12, indicated the resident had a self-care deficit related to a CVA with left hemiplegia. Approaches were indicated as providing a shower twice weekly with partial baths in between, encouraging the resident to do as much as possible for herself and to have hygiene/grooming equipment within easy reach. Review of Resident #C's showering records indicated she had a shower on 11-2-12, 11-6-12, 11-9-12 and 11-13-12. The shower record on 11-2-12, 11-6-12 and 11-9-12		* Residents who reside in this facility have the potential to be affected by the alleged deficient practice.* All nursing staff have been inserviced by the Director of Nursing and/or designee on proper nail care techniques and expectations of such by December 11, 2012.*Rounds will be conducted on all shifts by Director of Nursing and/or designee to make observations of all residents' nails to ensure adequate nail care is provided.*Skills validations related to nail care will be completed on all nursing staff by the director of nursing and/or designee by December 11, 2012.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** * All nursing staff have been inserviced by the Director of Nursing and/or designee on accommodation of needs by December 11, 2012.*Rounds will be conducted on all shifts by Director of Nursing and/or designee to make observations of all residents' nails to ensure adequate nail care is provided.* Skills validations related to accommodation of needs will be completed on nursing staff by the Director of Nursing and/or designee by December 11, 2012.* The Director of Nursing is responsible for compliance related to resident care.*	

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	indicated in the comments section that nail care was provided. The shower record on 11-13-12 did not indicate any specific information regarding nail care. In interview with CNA #1 on 11-16-12 at 9:42 a.m., with CNA #2 on 11-16-12 at 10:09 a.m. and CNA #3 on 11-16-12 at 11:00 a.m., each indicated residents receive showers or baths twice weekly. During the shower or bath times, each indicated nail care is provided to residents. Each indicated that nails are to be checked and provided care to on a daily, as needed, basis. Each indicated the licensed nurses clip or trim the nails of diabetic residents and the CNAs may clip or trim the nails of non-diabetic residents. This Federal tag relates to Complaint IN00119399. 3.1-38(a)(2)(A) 3.1-38(a)(3)(E)		Non-compliance with nail care for our residents may result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * Accommodation of Needs CQI tool will be utilized by the Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months, quarterly x1 for at least 6 months.* Audit tools will be submitted to the CQI committee and if 95% compliance is not achieved , action plans will be developed.	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure documentation of medication administration times were properly recorded and accurate, for 1 of 3 residents reviewed for pain control in a sample of 4, in which one resident received medications, including narcotics and anti-anxiety agents, as well as multiple other medications, not at the physician-ordered time and documented the medications as if given on time. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 11-15-12 at 4:32 p.m. Her diagnoses included, but were not limited to, chronic back pain, muscle atrophy, peripheral neuropathy,	F0514	**F 514 Resident Records-Complete/Accurate/Accessible** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Resident B was sent to the local hospital for treatment. Resident B returned to facility that day with no injury. *Resident B receives medications the prescribing physician has ordered.	12/11/2012

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	congestive heart failure, anxiety, dementia and osteoporosis. Review of her most recent Minimum Data Set (MDS) assessment, dated 10-1-12, indicated she had mild cognitive impairment. It indicated she had frequent, severe pain for which she received pain medications on a routine basis, as well as on an "as needed" or "prn" basis. Review of the nursing notes, dated 10-22-12 at 8:05 a.m., indicated "Noticed res [resident] during breakfast not eating, when attempted to talk to res, res was extremely hard to arouse. Res will open eyes for a second, and when responds unable to understand what she is saying..." The note then indicated vital signs were checked and the physician notified. The physician ordered for the resident to be sent to the local ER for evaluation and treatment. Notes indicated the resident's POA (power of attorney) was notified of the resident's change in condition and the ambulance was on site by 8:40 a.m. to transport the resident to the local ER. In interview with the Director of Nursing (DON) on 11-16-12 at 1:10 p.m., she indicated the facility		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * Director of Nursing and/or designee will conduct rounds on all shifts to monitor the timeliness of the medication administration pass. * All licensed staff have been inserviced by the Director of Nursing and/or designee on proper medication administration techniques by December 11, 2012. * Skills validations related to medication administration were completed on all licensed staff on all shifts by the Director of Nursing and/or designee by December 11, 2012. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** * Director of Nursing and/or designee will conduct rounds on all shifts to monitor the timeliness of the medication administration	

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	conducted an investigation into the circumstances of the resident's status. A document entitled, "Employee Communication Form," dated 10-23-12, indicated on 10-22-12 at approximately 8:10 a.m., the DON was notified that RN #1 had administered Resident #B's 8:00 a.m. medications at approximately 6:00 a.m. This document indicated, "This noncompliant action resulted in a resident being transported to the Emergency Room and noted to have Narcotic Depression [sic.] The resident then received Narcan x2 [twice] to reverse the Narcotic Depression." The DON indicated "If I recall, she clocked out at 6:34 a.m., but signed the meds out for 7:00 a.m. and told us she gave them around 6:00 a.m. She didn't want to stay over that morning and she said that was her way of helping the day nurse." A copy of RN #1's time clock documentation indicated she clocked in on 10-21-12 at 9:54 p.m. and clocked out on 10-22-12 at 6:34 a.m. In interview with the Administrator on 11-16-12 at 1:10 p.m., she indicated RN #1 "seemed to have no remorse whatsoever in regards to what happened to the resident or that she		pass. * All licensed staff have been inserviced by the Director of Nursing and/or designee on medication administration techniques/med errors by December 11, 2012. * Skills validations related to medication administration will be completed on all licensed staff on all shifts by the Director of Nursing and/or designee by December 11, 2012. * The Director of Nursing is responsible for compliance related to medication administration. *Non-compliance with medication administration procedures may result in further education, and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * A Medication Errors CQI tool will be utilized by the Director of Nursing and/or designee weekly x 4 weeks, monthly x 2, quarterly x 1 for at least 6 months. * Audit tools will be submitted to the CQI committee and if 95% compliance is not achieved, action plans will be developed.	

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	falsified records." The Administer indicated RN #1 was terminated from employment at the facility. In interview with Resident #B on 11-16-12 at 2:40 p.m., she indicated she was sent to the local ER "not too long ago. The doctor there told me the nurse [at the facility] gave me too much pain medicine...they gave me some kind of medicine that snapped me right out of it." In a written statement by RN #1, dated 10-23-12, she indicated, "On the night shift we start our 6A meds at 4A. On [10-22-12], I gave [initials of Resident #B] her Percocet at 4A and then her 8A meds at 6A When I worked 2-10 [p.m.], we started our 8P meds at 6P, so I did not think this was wrong & that I was doing anything wrong...I was trying to help the day nurse out before I had to leave..." In a written statement from LPN #1, dated 10-23-12, she indicated, "When I got to work at 5:55A, [name of RN #1] was sitting at the nurse's desk waiting on relief. When we were getting report, [name of RN #1] told me she had already gave all 8A meds on the short hall on [name of hallway] because she was going to be mandated to stay and [name of RN			

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	#1] stated, 'I am not staying over.'" Review of Resident #B's physician orders and Medication Administration Record (MAR) indicated she was physician ordered for Percocet, a pain medication, 10/325 mg (milligrams) 2 tablets by mouth every 6 hours at 6:00 a.m., 12 noon, 6:00 p.m. and 12 midnight daily, Ativan 0.5 mg, an antianxiety medication three times daily by mouth at 8:00 a.m., 12 noon and 8:00 p.m., and Oxycontin CR 20 mg every 12 hours by mouth at 8:00 a.m. and 8:00 p.m. Resident #B's narcotic count log indicated the Percocet was signed out by RN #1 as administered on 10-22-12 at 6:00 a.m., the Ativan was signed out by RN #1 as administered on 10-22-12 at 7:00 a.m. and the Oxycontin CR was signed out by RN #1 as administered at 7:00 a.m. Other medications ordered for a morning dose and initialed as administered by RN #1 on 10-22-12 were as follows: -Aricept 10 mg once daily by mouth at 8:00 a.m. -diltiazem 240 mg ER once daily by mouth at 8:00 a.m. -Colace 100 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -Augmentin 875 mg twice daily by			

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	mouth for 10 days for bronchitis (start date of 10-18-12) at 9:00 a.m. and 9:00 p.m. -Antivert 25 mg three times a day for 7 days for dizziness (start date of 10-18-12), at 6:00 a.m., 2:00 p.m. and 10:00 p.m. -Neurontin 800 mg three times daily by mouth at 8:00 a.m., 12 noon and 4:00 p.m. -ferrous sulfate 325 mg once daily by mouth at 8:00 a.m. -Chloroseptic throat spray or generic brand, sprayed on throat four times daily at 6:00 a.m., 12 noon, 6:00 p.m. and 12 midnight. -potassium chloride 20 milliequivalents, 2 tablets, once daily by mouth at 8:00 a.m. -Lasix 40 mg once daily by mouth at 8:00 a.m. -Aggrenox 25-200 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -folic acid 1 mg once daily by mouth at 8:00 a.m. -Flonase Nasal Spray 0.05%, 1 spray each nostril once daily at 8:00 a.m. -Protonix 40 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -Zoloft 150 mg once daily by mouth at 8:00 a.m. -Advair Diskus 250/50 1 inhalation by mouth twice daily at 8:00 a.m. and 4:00 p.m. -Spiriva Handihaler, inhale contents			

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	155377	A. BUILDING 00 B. WING	11/19/2012

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	of 1 capsule once daily by mouth at 8:00 a.m. -Albuterol 0.083% (2.5mg in 3 milliliters of saline) 1 vial via nebulizer four times daily at 8:00 a.m., 12 noon, 4:00 p.m. and 8:00 p.m. -Lidoderm 5% Patch, apply one patch daily topically at 7:00 a.m. and remove daily at 7:00 p.m. -Coreg 6.25 mg twice daily by mouth at 8:00 a.m. and 4:00 p.m. -lisinopril 10 mg daily by mouth at 8:00 a.m. The Administrator provided a document entitled, "Charge Nurse Position Description" on 11-16-12 at 4:45 p.m. This document indicated, "...administers medications and specialized treatments...as prescribed to residents on unit according to physician orders and in compliance with facility policies and procedures..." This document was signed by RN #1 on 6-1-12. The Administrator provided a document entitled, "Medication Pass Procedure" on 11-16-12 at 4:45 p.m. This document indicated under the heading of "Skill," "Meds administered within 60 minutes before and/or after scheduled time ordered," that RN #1 had successfully passed this skill. This document was signed by RN #1			

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	on 6-9-12 and the instructor. This Federal tag relates to Complaint IN00118544. 3.1-50(a)(1) 3.1-50(a)(2)			

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F9999	State Finding: 3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food services supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of resident or residents. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to report to the Indiana State Department of Health (ISDH) an unusual occurrence of a resident receiving multiple medications within a short amount of time, including narcotics and anti-anxiety agents, and medications administered not at the times	F9999	**F 9999 Failure to Report-Administration and ManagementThe administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nesting or food services supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: 1) Immediately informing the division by telephone, followed**	12/11/2012

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	prescribed by the physician, which resulted in 1 of 3 residents reviewed for pain control in a sample of 4 being sent to the local emergency room and treated a for narcotic overdose. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 11-15-12 at 4:32 p.m. Her diagnoses included, but were not limited to, chronic back pain, muscle atrophy, peripheral neuropathy, congestive heart failure, anxiety, dementia and osteoporosis. Review of her most recent Minimum Data Set (MDS) assessment, dated 10-1-12, indicated she had mild cognitive impairment. It indicated she had frequent, severe pain for which she received pain medications on a routine basis, as well as on an "as needed" or "prn" basis. Review of the nursing notes, dated 10-22-12 at 8:05 a.m., indicated "Noticed res [resident] during breakfast not eating, when attempted to talk to res, res was extremely hard to arouse. Res will open eyes for a second, and when responds unable to understand what she is saying..." The note then indicated vital signs		**by written notice within twenty-four hours, of unusual occurrences that directly threaten the welfare, safety, or health of resident or residents.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** * Resident B was sent to the local hospital for treatment. Resident B returned to facility within same day with no injuries.* A report was sent to ISDH regarding medication error unusual occurrence. * A complete investigation was initiated at time of unusual occurrences regarding incident.* ISDH investigated unusual occurrence of Resident B **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice.* Director of Nursing and Executive Director have been inserviced by the Director of Nursing Consultant on reporting	

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	were checked and the physician notified. The physician ordered for the resident to be sent to the local ER for evaluation and treatment. Notes indicated the resident's POA (power of attorney) was notified of the resident's change in condition and the ambulance was on site by 8:40 a.m. to transport the resident to the local ER. An "ED [Emergency Department] Physician Documentation" form, dated 10-22-12, indicated Resident #B was treated that date for lethargy and altered mental status with no respiratory distress. It indicated she was discharged back to the facility at 2:56 p.m. with a discharge diagnosis of "narcotic overdose." A "Transport Report Form" from the local ER, dated 10-22-12, indicated the resident received 2 doses of Narcan, a medication used to manage or reverse opioid overdosage, and 1/2 liter of IV fluids. In interview with the Director of Nursing (DON) on 11-16-12 at 1:10 p.m., she indicated the facility conducted an investigation into the circumstances of the resident's status. A document entitled, "Employee Communication Form," dated 10-23-12, indicated on		unusual occurrences by December 11, 2012.* Any unusual occurrences will be reported per state/federal guidelines by the Executive Director within 24 hours of occurrence.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** * Director of Nursing and Executive Director have been inserviced by the Director of Nursing Consultant on reporting unusual occurrences by December 11, 2012.* Any unusual occurrences will be reported per state/federal guidelines by the Executive Director within 24 hours of occurrence.* The Executive Director is responsible for compliance related to reporting unusual occurrence.* Non-compliance with nail care for our residents may result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * Medication Error CQI tool which addresses notification of appropriate agencies will be utilized weekly x 4 weeks, monthly x 2 months, quarterly x1 for at least 6 months.* Audit tools will be submitted to the CQI committee	

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	10-22-12 at approximately 8:10 a.m., the DON was notified that RN #1 had administered Resident #B's 8:00 a.m. medications at approximately 6:00 a.m. This document indicated, "This noncompliant action resulted in a resident being transported to the Emergency Room and noted to have Narcotic Depression [sic.] The resident then received Narcan x2 [twice] to reverse the Narcotic Depression." The DON indicated "If I recall, she clocked out at 6:34 a.m., but signed the meds out for 7:00 a.m. and told us she gave them around 6:00 a.m. She didn't want to stay over that morning and she said that was her way of helping the day nurse." A copy of RN #1's time clock documentation indicated she clocked in on 10-21-12 at 9:54 p.m. and clocked out on 10-22-12 at 6:34 a.m. In interview with the Administrator on 11-16-12 at 1:10 p.m., she indicated RN #1 "seemed to have no remorse whatsoever in regards to what happened to the resident or that she falsified records." The Administer indicated RN #1 was terminated from employment at the facility. She indicated she notified the facility's corporate offices of the events with		and if 100% compliance is not achieved, action plans will be developed.	

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	Resident #B. She indicated she did not notify ISDH of the events with Resident #B. This state finding relates to Complaint IN00118544. 3.1-13(g)			